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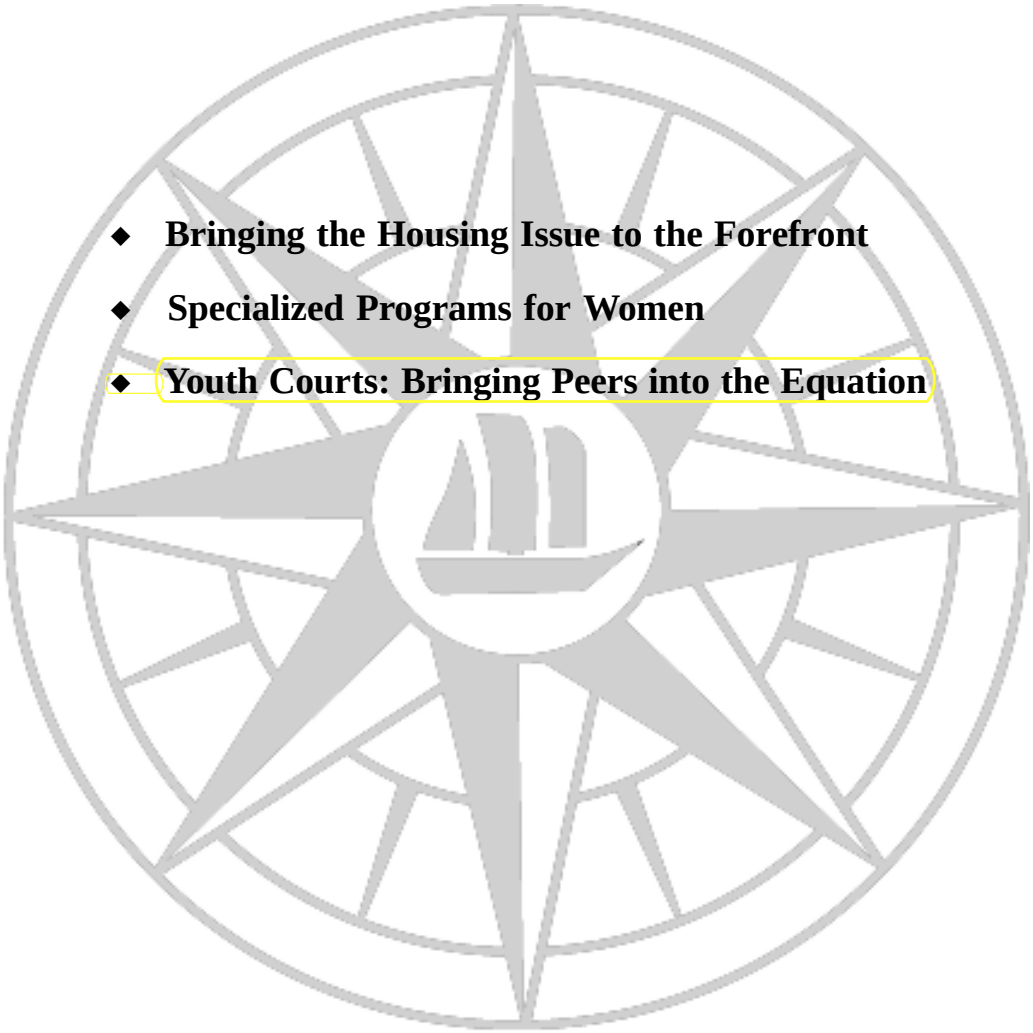
SPECIAL REPORT: INNOVATIONS IN BEHAVIORAL HEALTH

From the editors of *Alcoholism & Drug Abuse Weekly* and *Mental Health Weekly*



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- **Specialized Programs for Women**
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'Housing First' becoming the standard model for homeless populations

By Colleen Fitzpatrick

As a psychiatric outreach worker in New York City during the 1980s, Sam Tsemberis heard a lone, unified message from many of the chronically homeless people with mental illness whom he encountered.

"What I need is a place to live," they told him. "A place that's my own place. Where I don't have to live with a group of people. Where I don't have to live in treatment if I don't want to. Where I don't have to hide my beer under the couch when you come and visit."

The more Tsemberis heard and thought about this request, the more reasonable it sounded. Yet no such housing formally existed for chronically homeless people with mental illness, many of whom also had a substance abuse disorder.

Instead, the going model was — and largely remains — a "linear residential treatment program," which directs people through a continuum of services: outreach, then intermediary, usually congregate housing, and finally, permanent housing.

Furthermore, the rules for many supportive-housing programs often include that participants be clean and sober, and undergo psychiatric assessments, take medication if prescribed and engage in other treatment and services.

Tsemberis, who holds a doctorate in clinical community psychology, began to view that approach not only as inflexible and counter to what he was hearing in the streets, but also discriminatory.

Providers and policies were "requiring people with mental illness to cure their clinical condition before they could house them," he said. "There's something quite discriminatory about that. There is no other population for whom this is required."

Out of his experience came Pathways To Housing, Inc., which Tsemberis founded in 1992 with a $500,000 grant from the New York State Office of Mental Health and which is based on a "housing first" strategy.

Pathways' approach brings chronically homeless mentally ill people — 90 percent of whom have a substance abuse disorder — in from the streets and immediately places them in permanent, private-market apartments and other residences scattered throughout the city. Only after housing is secured does the Pathways staff bring on the services, in the form of assertive community treatment (ACT) teams.

The idea behind "housing first" is that providing a person with stabilized housing creates a foundation for recovery to begin. It's a consumer-driven model that assumes that if people with serious and persistent mental health disorders can survive on the streets — figuring out where to eat and sleep and how to receive a check from the Social Security office and protecting their physical safety — then managing an apartment is, as Tsemberis says, "a piece of cake."

Philip F. Mangano, the Bush administration's point person on homelessness, said that the model "says that housing is the appropriate nexus point for the delivery of services."

So far, about 85 percent of Pathways' 500 tenants have remained in their homes, according to a study of the program published in the April issue of the *American Journal of Public Health* (Vol. 94, No. 4).

Calling the strategy "groundbreaking," Mangano credits Tsemberis and the private, non-profit Corporation for Supportive Housing with expanding the "housing first" technology from the mental health field

Editor's Note

This special, combined issue of *Mental Health Weekly* and *Alcoholism & Drug Abuse Weekly* on Innovations in Behavioral Health is a joint effort of the Manisses editorial team. We decided to provide a combined issue because we have found that innovations in broad subject areas such as housing, special populations, employment and criminal justice tend to cut across both addiction and mental health programs.

We are also pleased to provide our subscribers with additional in-depth coverage that a special combined issue allows. We will follow this same format with our upcoming Special Issues: The Preview Issue, published in January, and the Workforce Issue, published in April. We will also make these special, combined issues available as stand-alone documents.

As we continue to meet the information needs of mental health and addiction professionals, we hope that you find this issue particularly useful and accessible. If you have any suggestions or comments, please e-mail them to bmcalarney@manisses.com.

Brion McAlarney
Senior Managing Editor

where it originated to use with all vulnerable homeless populations.

The approach got a huge national boost in 2003, when the federal Interagency Council on Homelessness (ICH), where Mangano is executive director, announced its chronic homelessness initiative. The initiative awarded some $35 million to nearly a dozen localities nationwide to implement innovative approaches to addressing homelessness, including incorporating "housing first" strategies.

Communities such as Philadelphia, San Francisco, Denver, Fort Lauderdale and northern Louisiana are in various stages of adopting elements of "housing first" approaches.

Though obstacles remain to widespread implementation, many housing experts view it as the standard for sheltering people with chronic disabilities.

"This works for the most chronically disabled people," says Ann O'Hara, associate director of the Technical Assistance Collaborative in Boston. "It gets them affordable, decent housing, and helps them engage with the mental health system in ways that meet their felt needs first. This helps them build the trust that will help them get the other services."

"To a housing professional, it's completely common sense — you address the issue of housing and that in and of itself is a measurable outcome."

Ann O'Hara

In New York City, with its homeless population of about 38,000, most people who become Pathways tenants are identified through staff outreach efforts. Some tenants are referred by city outreach teams, shelters and drop-in centers. Data from 1999 show that 65 percent had last lived on the streets, 18 percent in shelters and 7 percent in treatment facilities.

Participants must pay 30 percent of their income toward rent. This amounts to about $200 a month after tenants begin receiving monthly disability checks of $500 to $800. About 80 of the 500 tenants have Section 8 federal housing vouchers. For the rest, Pathways pays the difference, using subsidies from the U.S. Department of Housing and Urban Development's Shelter Plus Care program and from New York's state mental health office. A unit costs $20,000 on average.

Not surprisingly, the biggest challenge is helping members find apartments at fair market rent, though Tsemberis says that landlords like working with Pathways tenants because rental payments are guaranteed. Housing is scattered among buildings mainly throughout the city's lower-middle-class sections; Pathways has a network of 115 landlords.

Once a member is housed, Pathways staff converges in the residence with offers of treatment, support and other services. Each tenant is assigned an ACT team, a community-based, multidisciplinary team of mental health professionals that is available 'round-the-clock' to provide or link the tenant with services.

Beyond their financial obligations, tenants must fulfill only one requirement: to meet with a service coordinator at least twice a month during their first year of tenancy. Though the intensive and wide-ranging psychiatric, supportive and substance abuse treatment services are available, tenants do not have to use them. Many, however, do, Tsemberis says.

Though the "housing first" strategy emerged from the mental health field, it nonetheless does not sit well with all behavioral health professionals.

It embraces a harm-reduction rather than abstinence model of addiction treatment, which flies in the face of the philosophy espoused by many addiction treatment programs and the people who run them.

Another reason that some behavioral health professionals are skeptical is that the strategy removes control from professionals and gives it to consumers.

"It's a challenge to take people at their word, and give them an apartment to go into, a place of their own," Tsemberis says. He recalls his own training as a psychologist, and being taught that mental illness is incapacitating, and that people with mental disorders couldn't possibly make it on their own.

They can, of course, Tsemberis says, adding that "the most anxious part of the decision-making is to turn the control for the decision over to the consumer…A lot of providers are uncomfortable doing that."

O'Hara weighs in on this point, as well. "Housing first" strategies recognize that "people need to be housed, and the fact that they may not be engaged in the types of services that some mental health clinicians say they should be is really not relevant.

"What's relevant is what kind of housing do people need to be stabilized so they can receive services," said O'Hara. "To a housing professional, it's completely common sense. It's very logical: you address the issue of housing and that in and of itself is a measurable outcome."

She identifies some obstacles to the strategy's widespread implementation: a limit to the number of HUD's Section 8 vouchers. "We haven't seen any new Section 8

vouchers since 2001. The numbers of subsidies coming out of the homeless program are just not enough to deal with the demand. It's a huge barrier," O'Hara says.

The numbers underscore that difficulty. People getting Supplemental Security Income (SSI) payments take home just 18 percent of the median income, on average. There are some 4.9 million SSI recipients; perhaps one-third of them are people with serious mental illness. An estimated 440,000 people with disabilities have Section 8 vouchers; it's unclear how many of those are people with mental health problems.

Another obstacle, O'Hara says, is finding ways to pay for the behavioral health and other services that accompany the model. "Some states are better positioned than others to bill Medicaid for the ACT services to go along with this," she says. For example, some states are rewriting their Medicaid waivers to allow for reimbursement of services under the rehabilitation option.

Despite the challenges, Tsemberis is encouraged by the interest he is seeing around the country in "housing first" models. "The tide has turned, in a way, and people have seen there's a usefulness to it. And it's effective because it's sympatico with the consumer," he says. "For all of the talk, it is based on love, respect and creating possibilities for people with mental illness."

For more information, go to: www.pathwaystohousing.org.

YOUTH COURTS RUN BY BEHAVIORAL HEALTH PROGRAMS MORE EFFECTIVE IN ADDRESSING UNDERLYING ISSUES

By Colleen Fitzpatrick

Courts that rely on young people to participate in meting out justice to their peers who run afoul of the law have burgeoned in recent years. There are about 950 youth courts in 48 states, up from about 78 courts in 1994.

Most fall under the auspices of the criminal justice system, including district attorneys' offices and police or probation departments, or are run by non-profit groups, such as boys and girls clubs and YMCA's. Some are school-based, while others are overseen by municipalities.

Only a few courts — perhaps a dozen — are operated by behavioral health programs, primarily alcohol and drug treatment and prevention programs.

Yet youth courts driven by addiction prevention and treatment or mental health groups make good sense, says Tracy Godwin Mullins, director of the National Youth Court Center in Lexington, K.Y. Youth courts are in a unique position to see and address all the behaviors a young person is manifesting — including substance abuse problems.

"Someone might have a shoplifting offense, but on deeper introspection, it comes out that they were using at the time they happened to engage in the illegal behavior," says Godwin Mullins.

While many of the courts have established links to a drug and alcohol program, those that are actually run by such programs are often in the best position to respond most quickly to any underlying substance abuse problem, she says.

Elizabeth McGonigal, who, as director of youth treatment services with the Northern Illinois Council on Alcoholism and Substance Abuse (NICASA), manages the youth court in Round Lake, IL, agrees. Young people "have immediate access to all of our services and all of our staff." Her agency's expertise "is built right into teen court," she said.

Eduardo F. Cue is program director of the Santa Barbara Teen Court in California, which is handled by the Council on Alcoholism and Drug Abuse, Santa Barbara (CADA SB). Cue cites another advantage to vesting the court in a treatment rather than law-enforcement agency: "It takes away a fear of the court system, which is geared totally toward being punitive instead of corrective…

"There's this power that kids have on one another...They have to save face with each other. Because of this influence — call it pressure if you like — kids feel compelled to complete this," says Cue, whose Santa Barbara court won recognition this year from the National Council on Alcoholism and Drug Dependence (NCADD).

Like mental health and drug courts, youth courts, also called teen, peer and student courts, are an alternative to the mainstream justice system. Their guiding principle is simple: young offenders accept responsibility for their misdemeanor actions, undergo scrutiny by their peers, and make restitution to the victims and community through such actions as writing letters of apology and performing community service.

Teen court "can be extremely confrontal for a young person and sends a strong message to youth in the community that their peers do not condone delinquent and/or alcohol- and drug-related behaviors," says Cue,

who adds that up to 65 percent of youths entering the Santa Barbara teen court admit to using or abusing drugs or alcohol.

One goal of teen court is to reduce the likelihood that young people will engage in delinquent behavior. Another is to help them become good citizens by teaching leadership, coping and other skills that enable them to advance in life as they take an active role in addressing crime-related issues in their communities.

Each community devises its own youth-court structure, which generally lines up with one of four approaches. They are:

- Adult judge model, in which youths serve as the lawyers and jurors while an adult presides.
- Youth judge model, in which youths serve as lawyers, jurors and judges.
- Youth tribunal model, which involve only youth attorneys and judges, and no jurors.
- Peer jury model, in which a case presenter states the facts of the case and a youth jury questions the offender, with a volunteer adult judge frequently presiding.

Santa Barbara's eight teen courts are run largely according to the peer jury model. Here's how it works:

The prosecution-diversion court is available to many first-time misdemeanor offenders between the ages of 10 and 18. Youths generally are referred to court by the probation department, and participation is voluntary.

The courts handle misdemeanor offenses, such as shoplifting, petty theft, assault or battery without serious injury, possession of stolen property, vandalism, some drug and alcohol offenses, and for school-referred cases, truancy and aggressive behavior.

Youthful offenders must claim responsibility for their acts, and agree to comply with the conditions imposed by a jury of their peers. They also must serve in later cases as jury members, perform other community service and attend educational classes around topics such as conflict resolution, life choices, crime awareness and drug and alcohol education.

Youths charged with drug and alcohol offenses undergo six sessions in substance abuse education, accompanied by drug-testing. Referrals to more intensive services or programs are possible; Cue and McGonigal both say that such referrals are made for 10 percent to 20 percent of their youth court participants.

The Santa Barbara program also requires parents to attend their child's intake session and court hearing. Parents — especially those whose children are charged with drug and alcohol offenses — are urged to take educational courses, parenting classes or family counseling to teach them disciplinary skills and how to more effectively handle their child's behavior. Ongoing support groups are available to parents who complete the education sessions. Three-quarters of parents who attend the first session complete the series, says Cue.

Youth court sentences generally are more stringent than the fine or probationary term that would be imposed in the traditional juvenile court, says Cue.

Santa Barbara's juvenile justice judges agree to take no further action against offenders who successfully complete their contract, nor do they have a criminal record. Prosecution continues for those who fail to complete their contract.

"A young person might say that they're only hurting themselves by drinking or taking drugs — we know that's not true."

Tracy Godwin Mullins

In Santa Barbara, about 60 volunteer youths serve as juries and case presenters each week. The case presenter gives an overview, with the facts, then jurors directly ask the offender about his or her behavior and the offense, and determine the sentence. The judge — any one of 25 volunteer attorneys from the community — simply "brings professional decorum to the proceedings and serves as a mentor," Cue says.

Since its inception in 1992, the Santa Barbara courts have seen some 3,600 cases. Last year, 90 percent of the 486 cases were successfully completed. Of those, 87 percent to 90 percent do not reoffend within a year of completing the program, dropping to 85 percent to 87 percent after two years and 82 percent to 80 percent after three years, he says.

By comparison, more than a quarter of the youths sentenced to probation through the traditional juvenile justice system reoffend after the first year, Cue says.

In Round Lake, 938 young people participated in teen court from 1996, when it began, to 2002. Of those, 806 completed their contracts. About 28 percent have reoffended, compared with 55 percent for young people who attended the more traditional courts, McGonigal says.

A former gang investigator, Cue believes one reason the numbers are more favorable for teen court is because it eschews the "deterrence-based-upon-fear" approach. Teen court is "teaching kids to respect the law. They are the law. They have a voice in it."

The courts are funded in any number of ways,

including with taxpayer money that comes through human service, law-enforcement and education agencies, as well as with private donations, and in some cases sliding-scale fees to families.

As youth courts continue their evolution, many more are embracing the principle of restorative justice, or as Godwin Mullins says, "elevating the consciousness of respondents to look at how their actions affect the community…

"The biggest changes I see are more programs recognizing the victims of crimes and all the stakeholders, and allowing them to participate," says Godwin Mullins. In their early days, the courts "didn't really make an effort to include the victims…

No one knows as well as addiction professionals the impact an individual's behavior can have on others. Crime "has ramifications for everyone — there is no such thing as the victimless crime," she says. "Often, a young person might say that they're only hurting themselves by drinking or taking drugs. We know that's not true. Families in particular can be hurt by their behavior….Youth courts that educate about empathy and responsibility can be a support to families in terms of healing, repairing broken trust."

Communities in Connecticut and New Jersey — the only two states that lack youth courts — have expressed interest in starting them, and youth courts there may be operating within a year, says Godwin Mullins.

For more information about youth courts nationally, go to the National Youth Court Center: www.youthcourt.net. For the youth courts in Santa Barbara, go to: www.cadasb.org and click on "teen court," and in Round Lake, go to: www.nicasa.org and click on "teen court" under "Select A Topic."

PLETHORA OF SPECIALIZED PROGRAMS EMERGING TO SUPPORT WOMEN, PRESERVE FAMILIES

By Valerie A. Canady

Unique programs and services cropping up across the country are not only assisting women with substance abuse issues, but provide services and support, including housing and parenting assistance for their family members, in many cases even after they leave the treatment programs.

The Caron Foundation, a Pennsylvania-based drug and alcohol addiction treatment organization, issued a report in 2002, *Women & Addiction: Gender Issues in Abuse and Treatment*, that found that women are more likely to complete treatment and experience a better rate of recovery in women-only treatment programs than those in mixed-gender programs.

The Substance Abuse and Mental Health Services Administration (SAMHSA) recently awarded 14 grants totaling $21 million over three years for pregnant and postpartum women in residential substance abuse treatment programs.

"We are trying to see that women get treatment services and other services they need and to prepare them to be better mothers and to work on a lot of things," said Leah Young, SAMHSA spokesperson. The funding will also assist children suffering from the effects of maternal drug use, said Young.

The grantees, who represent residential treatment and support programs in Alaska, Florida, Kentucky, Texas and Wisconsin and other locations, will receive $500,000 per year for three years.

The Millennium Center

While the idea of providing women-and family-centered treatment programs receives support from the federal level, the front-line work is done, as usual, at the local level.

One such example is an innovative facility in a small, rural county in Georgia that offers women with substance abuse problems and their families treatment, residence and support services, all within the confines of a 16-acre, self-contained gated community.

The Millennium Center for Family Development is a therapeutic community which represents an integrated effort to build a comprehensive, state-of-the art evidence-based program for families in which one or both parents have a substance use disorder.

The Cuthbert, Ga.-based program includes a number of clinical services for women including addiction treatment, family therapy, couples therapy, health education and medical services, life skills development and case management.

The two-year program has served 49 families, including 113 children. The Millennium Center campus consists of two, three and four-bedroom units and serves up to 20 families at a time.

"We treat the entire family — all of the children are able to come as well as partners and spouses," said Dana P. Glass, LMSW, director of the Millennium Center. "Lots of residential programs may limit the number of

children, if they allow children to come at all.

"It's just amazing when you bring all the families together what can be accomplished," said Glass. "The goal of the program is to help families establish tools for recovery and self-sufficiency, being able to parent and care for their children more effectively and to stay clean and sober."

Spouses, partners and older siblings can stay at the facility for the duration of the program which lasts one year, said Glass. Aftercare services and follow-up referral are also available, said Glass. "This is a very extreme population," said Glass. Sometimes "it's their last chance before children are removed from the home or their parental rights are terminated."

The center was developed in 2002 by the University of Miami and the Columbus, Ga.-based New Horizons Community Service Board, a non-profit organization providing mental health, developmental disability and addictive disease services to residents of several counties in West Central Georgia.

"The University of Miami was heavily involved in our planning process, so that our treatment matched the evaluation piece," said Glass. "Initially, we met to identify the outcomes that we wanted our program to achieve. These were enabling individuals to achieve long-term recovery, self-sufficiency, and the reunification of families."

Glass added, "Since the outcomes were identified first, we then worked backward to develop our treatment program to help meet the desired outcomes. They also assisted us in identifying and researching the different treatment components."

Funding for the Millennium Center comes from numerous sources, said Glass. The funding for the treatment component of the program comes directly from the state Department of Human Services' Department of Family and Children Services (DFCS) division, said Glass.

"We were given $1.2 million specifically for the treatment portion of the program over a three-year period," said Glass. The Department of Community Affairs assisted the local Cuthbert Housing Authority in securing a low-interest loan to build the facilities and our agency leases them, said Glass. "Each home's rent is supported by a Section 8 project-based voucher."

The population served includes women 18 or older who are pregnant or parenting and who have or will have custody of their children within six months of admission to treatment. They also are eligible for Section 8 Housing and meet DFCS criteria.

The Millennium campus includes a building for therapeutic activities and an administrative building. The campus also offers a child development center, a neighborhood playground and technical college. Treatment group rooms are located in the administration building along with clinical staff offices and nurse and doctor offices.

Men's services at the center include addiction treatment, life skills, anti-domestic violence, job readiness and case management. "We have a men's counselor who is able to work with our men on campus individually," said Glass. "They also meet with our family therapist as well. If they too are in need of substance abuse services, they attend our local Substance Abuse Recovery Center, which is also a program under New Horizons CSB."

"The unique feature of the program is that it specializes in providing treatment to women who have had multiple failed treatment experiences in other programs."

Pamela Peterson-Baston

Glass added, "They provide outpatient substance abuse and mental health services, as well as psycho-social rehab at that site."

Officials say the federal, state and local partners are key to the center's success. Partners include the southwest Georgia Housing Development Corporation, the state Department of Community Affairs, the state Department of Labor Partnerships including DFCS, the Southwest Georgia Housing Development Corporation and the state Department of Community Affairs.

"The unique feature of the program is that it specializes in providing treatment to women who have had multiple failed treatment experiences in other programs," said Pamela Peterson-Baston, consultant for Solutions of Substance (S.O.S.) Inc. The Columbus, N.C.-based company provides consulting and training services to substance abuse prevention and treatment providers. "One of the reasons for [previous] failures is due to the lack of a holistic approach."

The women at the Millennium Center have had a very long history of substance use and they have extreme parenting and economic issues, said Peterson-Baston, program consultant for the Millennium Center. "Their challenges include poor parenting skills, no family support, and many have a 20-year drug addiction history that includes crack/cocaine," said Peterson-Baston.

"The center provides more than addiction counseling," said Peterson-Baston. "We're providing a much

more holistic approach than what had been traditionally available in drug treatment."

The Millennium program is modeled after Safe Port, a Key West, Fla.-based program for women with substance abuse issues and their children, said Peterson-Baston, former director of the program. "We wanted to replicate the family nature of the Safe Port program but take it to the next level," said Peterson-Baston. "In '94 we didn't have the advantages of evidence-based programs that are now available."

"Every clinical, educational [component] was evidence-based," said Preston-Baston. "That distinguished it from Safe Port, which relied on best practices."

Positive outcomes

A recent report by the Millennium Center indicates that at the end of August 2004, of the 49 families who had entered Millennium, 18 were completing their first year of treatment, 20 had graduated from the program, and 11 had been discharged before completing treatment. The retention rate currently stands at 78 percent, according to the report.

The report found that 53 percent of all adults entering Safe Port, the model program for the Millennium Center, completed it. According to the report, the Millennium Center retention rate was well above many other programs in a cross-site study where the completion rate was well below 50 percent.

The report found the number of children returned to their parent's custody as a result of participating in the Millennium Center is 38. An additional 29 children have been prevented from ever being removed from their parents through services provided at the center, according to the report.

The biggest hurdle in pulling the program together was finding a willing public housing authority that would want to work with us in a recovery program, said Peterson-Baston. "Some public housing authorities may want to kick someone out who is addicted," said Peterson-Baston.

Perhaps the most significant difference was also developing more contemporary policies, said Peterson-Baston. The value added to an innovative program is "greatly diminished by archaic policies. Patients are not kicked out of the program for relapsing," said Peterson-Baston. "The staff is working more in partnership with the client. It's a therapeutic alliance — they work through the relapse as long as the client is making incremental progress toward an abstinent lifestyle.

Peterson-Baston added that more policies are needed with the goal of keeping families together.

"For the most part, these are some of the nicest homes the women have ever experienced," said Peterson-Baston. "It's quasi-residential; it looks and operates like a residential program. Families are responsible for paying their own rent. The families are on economic assistance and TANF (Temporary Assistance for Needy Families) is the vehicle to allow them to pay their own rent."

When the women and their families leave the program, they can become eligible for a Section 8 Housing and Urban Development (HUD) voucher, which allows them to rent a home or an apartment in the community of their choice at the rate the voucher pays.

"Each successful graduate is able to leave here with a new Section 8 voucher to obtain housing" in the state or elsewhere around the country, said Glass. After completion of the program, families are also linked to other services which mirror services at the Millennium, whether it's family or individual counseling or community-supported services, said Glass.

Although the facility is located in a rural community, the center utilizes all of the resources in the community, said Peterson-Baston. The college is within walking distance from the campus where clients can receive computer training and prepare for their GED (General Educational Development) exam, said Peterson-Baston.

"When you see how rural this [community is] it gives you hope," said Peterson-Baston. "If they can pull this program off in Randolph County in Georgia, anybody can pull off such a program."

For more information about the clinical design of the Millennium Center, call Pamela Peterson-Baston at (828) 894-6558. For program-specific information, call Dana P. Glass at (866) 500-5667 or (229) 732-5602.

TIES Program Helps Pregnant Women

Helping pregnant, addicted women become drug-free is a major goal of Kansas City, Mo.-based program, which also provides counseling support, assistance with parenting skills and connects families to community services.

The Team for Infants Endangered by Substance Abuse (TIES) is a 14-year program that works primarily to prevent the abandonment of infants born to parents with drug addiction. Program specialists assess family resources and needs, engage families in a problem-solving relationship and develop a home-based intervention plan for them.

TIES is headed by Kansas City, Mo.-based Children's Mercy Hospital, which enrolls mothers who are expecting and new mothers who have used illegal drugs during their pregnancy. The women participants receive a

number of services including substance abuse treatment, crisis intervention, counseling, child development and parenting education.

The program is a comprehensive, multi-agency program providing intensive, home-based services to pregnant and post-partum women and their families affected by substance abuse or HIV/AIDS.

The program has received a $1.8 million federal grant for four years, said Oneta Templeton McMann, director of TIES. The program has been funded through September 2008 at $450,000 a year. Additional funding support comes from Jackson County Community Backed, Anti-Drug Tax (COMBAT) funds, an anti-sales tax for prevention and treatment efforts.

The criteria for mothers in the program are that they must be at least 18 years old, pregnant or have a newborn exposed to alcohol or other drugs or are HIV-positive during pregnancy. The women who are referred to TIES are referred from a variety of sources including substance abuse treatment providers, the state child protection agency, health care providers, emergency and women's shelters and self-referrals.

The program involves a professional staff of five family specialists, include four social workers and a substance abuse counselor, each of whom is assigned to 10 families.

The program is run by a multi-agency consortium, said Templeton McMann. The 13-agency consortium involved with the program include ReDiscover Mental Health and Substance Abuse Services, the American Indian Council, Jackson County Children's Division and the Children's Place Day Treatment program.

"We connect families to other kinds of services or with child protective services," said Templeton McMann. "We identify who else is involved with the family, give voice to Mom's concerns, and look at how crisis-survival issues may be taking precedent over substance abuse treatment."

Families eligible for the program have access to their TIES specialist 24 hours-per-day by pager. The intervention is planned to last until the infant is 18 months old.

The specialist conducts an initial assessment of the family's resources and needs. They also contact other involved agencies to identify services, establish goals and progress.

Setting goals

Each family participant is involved in an individualized process. The five goals for participating mothers include becoming drug-free; improving parenting; securing adequate housing; achieving economic stability; and securing appropriate health care services.

A report of the program from Oct. 1, 2000 to Sept. 30, 2003 found that toxicology reports show 36 of the 50 births with valid screens to be drug-free at delivery. The women are assessed at intake, when the infant is three months, when the infant is 13 months and at discharge. The report showed a significant change toward the drug-free goal with the highest scores reflected at the infant age of three months.

Templeton McMann said the physical needs of the mothers are also addressed. "We try to provide a complete menu of things families can work on all the while trying to confront them with the consequences of substance abuse."

Housing is an important issue for the women when they leave the program, said Templeton McMann. "We really see housing as a crucial issue," said Templeton McMann. "If we are asking them to return to the same housing situation, the chances of success are very slim."

Templeton McMann said they help women apply for public assistance benefits, subsidized housing and help their families find shelter or assist with landlord issues.

"Not doing anything is much more expensive in terms of health care and incarceration," said Templeton McMann.

For more information about the TIES program, call (816) 234-3021.

'Let's Start' Program Supports Women After Prison

A support group for women in St. Louis, which began 14 years ago following an informal conversation between three women who were formerly incarcerated, and a nun, has reached hundreds of women, many of whom struggle with addiction issues.

The 'Let's Start' program provides a support process to assist women in transition from prison into the community. The program provides information and referrals about treatment programs to women requesting help with substance abuse, addiction and abuse-related problems.

"The goal is a support process for women coming out of prison," said Sister Jackie Toben, SSND (School Sisters of Notre Dame). "The program provides support, encouragement and personal development and helps to reduce recidivism of women offenders. The majority of them are addicted to drugs."

Toben added, "The long-term goal is to keep people out of prison and provide community treatment so that

women and their families can stay together."

The program is different because the women themselves are the leaders of the group, said Toben. "What makes this program unique is that the whole process is coordinated by the women themselves — women who have experienced incarceration or were addicts," said Toben. "They take responsibility for facilitating support groups, making presentations to community organizations, and educating groups and legislators about criminal justice issues."

Group sessions are held every Tuesday at St. Vincent's Church and involves 30 to 50 women, said Toben. "The relationships are established," said Toben. "The women stay and come for as long as they need to." In 2003, approximately 212 women participated in Let's Start, said Toben.

The not-for-profit organization relies on grants, private donations, foundation support and the group's own fundraising efforts, said Toben. "Our budget is small, under $100,000 annually," said Toben. "We do our own fundraising and we write for grants."

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Sister Jackie Toben, SSND

Some of the women have had substance abuse treatment while incarcerated while others continue to receive treatment following incarceration. "We do make [treatment] referrals," said Toben. "I know that treatment works as evidenced by the women in the group and the ability of the women who had treatment to deal with their ongoing struggles in a productive way," said Toben. "You can almost tell who has had treatment and who hasn't."

While the St. Louis area has numerous treatment facilities, Toben said it is amazing how difficult it is getting the women into treatment, especially when they need to get in-house treatment and more long-term treatment. "Sometimes they need more than 30 days," she said. One of the facilities that some of the women in the group have been to is the St. Louis-based Queen of Peace, an inpatient facility run by Catholic Charities, said Toben.

A recent discussion among Let's Start participants involved the challenges of raising children, said Toben. "The women indicated that when they were using drugs they didn't worry about it and now that they are off drugs they want to establish a relationship with their children," said Toben.

Let's Start involves service, outreach and education in the broader community. The program also involves advocacy efforts and community organizing around issues that impact the participants' lives, said Toben.

Earlier this year, Let's Start participants met with sponsors of H.B. 1379, which would allow courts to order community-based substance abuse treatment to nonviolent offenders. The state legislation did not pass, said Toben. The next legislative session is scheduled in January and there will probably be follow-up on the bill, said Toben.

Women hear about the program through word-of-mouth, through the organization's newsletter and by their contacts with the prison system and treatment centers, said Toben.

Youth, caregiver groups

The Let's Start Youth Group began in 1997 to offer support to the young women whose mothers have either been incarcerated or used drugs. Like its adult counterpart, the group is conducted by the young women themselves, whose ages range from 14 to 21, said Toben.

The youth group offers weekly support, individual follow-up and referrals to mentors, and offers teens support in dealing with peer pressure and relationships.

The Let's Start Caregivers Group also formed in 1997 to offer support to grandmothers, aunts and friends who care for children while their mothers are incarcerated or using drugs. The group is coordinated by the caregivers themselves. The group of six-to-eight participants is smaller because the women are older and raising children. Weekly meetings may not always be as convenient for them, said Toben, who added that she helped form another Let's Start program in Baltimore about two years ago.

Community outreach efforts for the women of Let's Start include theater-like performances of their stories to churches, social agencies, high schools, college classes and community organizations. The "Stories of Hope" presentation discusses life before the prison experience, the prison experience itself, life after prison and the process of change, said Toben.

While they don't charge a fee, the group does accept donations for the performances, said Toben. "We feel the performance is more important than the amount of money raised off of it," said Toben.

For more information, visit www.letsstart.org.